DRAFT 7/14/08

Commonwealth of Massachusetts
Health Care Quality and Cost Council
Two Boylston Street, 5th floor
Boston, MA 02116

617-988-3360 • Fax 617-727-7662 • TTY 617-988-3175
www.mass.gov/healthcare

DEVAL L. PATRICK
Governor

TIMOTHY P. MURRAY
Lieutenant Governor

JUDYANN BIGBY, M.D.
Chair

KATHARINE LONDON
Executive Director

Health Care Quality and Cost Council
Meeting Minutes
Wednesday, June 18, 2008
1:00-4:00pm
One Ashburton Place, 21st Floor
Boston, MA

Council Members Present: JudyAnn Bigby (Chair), Kevin Beagan, Elizabeth Capstick, James Conway, Kenneth LaBresh, Joseph Lawler, Shannon Linde, Katharine London, Quentin Palfrey, Gregory Sullivan, Anya Rader Wallack, and Bob Johnson representing Dolores Mitchell.

Meeting called to order at 1:10 PM

I: Approval of Minutes of Council Meeting May 21, 2008

- Gregory Sullivan stated that he recalled discussing displaying cost data for each of four severity levels in a drop down menu on the website. He recalled this being discussed and agreed upon, which was not reflected accurately in the minutes, and no progress had been made toward this end. Mr. Sullivan wants to see the more specific data spread with threshold minimums of 40, 30, 20, 10 discharges.
- Councilors recalled that although the Council discussed the data issue and agreed that severity-level data may be a good idea, there was no formal proposal or vote, nor any agreement on the manner in which the more specific data would be displayed (in a drop down menu, etc.) and several members stated that the minutes were accurate.

- The Council approved the minutes of the May 21, 2008 Council meeting with following amendments:
  - Amend Item B to note that the Council would like to display cost data by severity level on the website.
  - Amend Item B to note that the Council wants to receive the data to be displayed on the website at least two weeks prior to voting to display it, and wants this data to include the number of discharges by DRG for each hospital.
  - Amend Item E to clarify that the Secretary introduced representatives of the Massachusetts Health Data Consortium to present their recommendations: she did not review their contract in the meeting.

II. Executive Director's Report

Personnel

Katharine London introduced the two summer interns, Young Joo, a graduate student at the Harvard School of Public Health, and Christine Lenihan, an undergraduate student at Connecticut College. Katharine also announced that she had received 38 resumes for the part time legal counsel and that interviews were being scheduled.

Public Hearing on Regulation 129 CMR 3.00: Disclosure of Health Care Claims Data.

The Council received testimony from the Massachusetts Association of Health Plans, the Massachusetts Medical Society, the Department of Public Health, the Massachusetts Hospital Association and Blue Cross Blue Shield of Massachusetts.

Budget

The Council has committed its entire FY08 budget of $1.3m. The Council's FY09 budget is $1.89 million in both the House and Senate budgets. At the retreat on June 30, the Council will work on establishing priorities for FY09 and allocating our budget accordingly.

Retreat

The Council's Retreat is scheduled for June 30th at Worcester State College. The major focus of the retreat will be to set the Council's priorities for FY09.

End of Life Care

At its June 4th meeting, the Communications and Transparency Committee suggested holding a hearing to discuss the Dartmouth findings on End of Life Care. Jim Conway discussed his thoughts about the best way to pursue this topic consistent with the Council's goals and recommendations. Katharine suggested referring this suggestion to the joint End of Life and Chronic Care Committee for follow-up.

Annual Meeting

Katharine London discussed the Annual Meeting and asked that Council members begin thinking about the planning process. She indicated that cost control and end of life care are potential topics for the meeting.

Website Update:

The launch of the website has been delayed due to several problems with the data. Katharine London indicated that provider records are the major problem. Council staff and DHCFP staff continue to work closely with the MHIC to develop a final hospital claims data extract. MHIC quickly corrected the initial error of assigning a small number of claims to the wrong hospital and is working now on identifying all hospital claims in the dataset and including them in the extract that will be used to calculate cost measures for the website.

Ms. London indicated that once a final extract is received from the MHIC, DHCFP staff will need up to two weeks to check the data, calculate cost measures, prepare hospital-specific reports, check the hospital reports, and deliver each hospital's report. The hospitals will then have 4 weeks to identify any issues and report them back to the Council staff.

III. Items for Discussion

A. Update on Health Claims Data Issues

Suanne Singer, Maine Health Information Center
Ms. Singer provided an update on the claims data submission process and also reported on the development of the data extract for calculating the website measures. She discussed the consolidation and validation process for the claims data.

Ms. Singer explained the issues MHIC has encountered, particularly in the validation process, and the methods being employed to correct them. There were five validation steps Suanne indicated that the majority of the problems arose during the validation of the division data and benchmark data received from payers.

Members suggested that the issues with the claims data collection highlights the need for administrative simplification in area of billing and claims standards. The Healthy Mass Administrative Simplification project may be a forum for discussing these issues.

B. Update on Website Development

Afsana Akhter from Medullan gave the Council an update on the website development process. Ms. Akhter reviewed the previous testing cycle and informed the Council of the user testing cycle recently completed by Council staff. This testing used structured test data, and examined functionality as well as possible enhancements. The Council was informed of the issues encountered during testing, and how they were addressed. Ms. Akhter also updated the Council on upcoming beta and accessibility testing.

John Freedman, M.D the Council's Clinical Consultant reviewed his recommendations regarding the quality measures and whether there is sufficient variability to assign star ratings to each procedure. Star ratings are used to provide user-friendly quality data, and should be used as often as reasonably possible. Dr. Freedman suggested using the percentage difference from best to worst in order to determine when it is reasonable to assign stars.

The Council's methodology (★ = bottom 15%, ★★ = between 15-50%, ★★★ = 50-85%, ★★★★ = top 15%) rates hospitals relative to other Massachusetts hospitals, not according to nationalized standards or objective standards. The methodology will always rate some hospitals as one star ★.The Council needs to decide when it is reasonable to assign stars.

Dr. Freedman reviewed a number of issues related to the rating methodology, including: hospitals bouncing between ratings due to small changes, no comparable benchmark from other states, lag of data, and updating schedules.
The current working threshold minimum sample size is 40 discharges, which is conservative. Maryland uses a minimum threshold of only 6 discharges to report severity adjusted charges (not payments, as Massachusetts will be reporting); Maryland did not conduct any analysis to determine this threshold. Establishing a lower minimum threshold would enable the Council to display data for more hospitals. However, a lower threshold would produce less reliable results, and might not meet the federal privacy protection standards. The reliability of the results of small sample sizes could be evaluated through repeated random sampling.

The Council would like to see how the data would be displayed based on smaller minimum thresholds.

The Council discussed concerns about the methodology used to assign star ratings and the positive and negative aspects of the rating system. If most hospitals perform well on a

measure, skewing the distribution of the data, there may be no meaningful difference between the hospitals rated with 4 stars or 3 stars.

The Council requested a follow-up discussion on the issues of how to assign stars, whether there is sufficient variation to assign stars, and how to select the minimum number of discharges for assigning a star rating.

C. MAHP Proposal for Collecting Race and Ethnicity Data

The Council's regulation 129 CMR 2.00 states:

Statistical Plan. The Council shall approve and publish a Statistical Plan. The Statistical Plan shall include steps that carriers must take by July 1, 2008 to begin collecting patient race and ethnicity data.

Mary Lou Buyse and Sara Gordon of MAHP presented suggestions its members developed for moving forward with this requirement. Their suggestions included geo/surname coding, followed by provider initiatives, and possibly health plans direct-to-member contact in order to quickly assert general race and ethnicity data to identify population level trends, and continuing with other measures to collect, over time, more complete and accurate race and ethnicity data.

MAHP reported that some of it's members previously collected such data, others did not. The following are some options suggested for moving forward with the requirements under regulation 129 CMR 2:00 which requires the collection of race and ethnicity data:

- Geo/Surname coding (effective for identifying population-level disparities)
- Provider Initiatives (point of contact more effective, yet samples limited to those who use services, not all provider groups collect information and no uniform standard for data sharing)
- Health Plans Direct-to-Member Contact (outreach, participants more likely to provide information, increased likelihood of reaching vulnerable populations, however may not reach members without health or benefit issues)
- Employer Data (enrollment) not always self-reported, limited to new enrollees

MAHP made the following Recommendations to the Council:

- Start with geo/surname coding
- Incorporate provider data
- Pilot programs for direct-to-member contact
- Develop a methodology for reporting whether patient race and ethnicity data was self-identified by the patient or estimated by the plan using geo/surname coding.

Blue Cross Blue Shield's Helen Luce noted that BCBSMA was not a member of MAHP, and that its opinions were not represented by the MAHP proposal and that they object to the use of geo/surname coding as a mean to collect race/ethnicity data.

The Council requested a follow-up discussion on this issue.

D. Report from Advisory Committee

The Advisory Committee expressed its support for the Council's mission and interest in serving a more active role in supporting the Council's work. The Advisory Committee requested that the Council consider designating a regular time slot on Council meeting agendas for Advisory Committee feedback and recommendations.

The Committee plans to hold separate monthly meetings and to develop a more defined role to support and advise the Council. The Advisory Committee is working on how to organize itself and will report back at a future meeting.

E. Reports on Progress toward Meeting the Council's Recommendations

The Council's recommendations included requests for a number of organizations to make progress reports to the Council at regular intervals. The Council invited staff from several state agencies to give progress reports on the following areas. Relevant excerpts from the Council's recommendations are provided below, along with the individuals who presented to the Council on these topics.

- Hospital-Acquired Infections
  John Auerbach – Department of Public Health (DPH)
  Paul Dreyer – Department of Public Health

  DPH Commissioner John Auerbach gave a report on DPH'S Hospital-Acquired Infection program. He discussed DPH's efforts to reduce hospital acquired infections, including through new regulations and reporting requirements. Commissioner Auerbach informed the Council of DPH's Technical Advisory Group and its hiring of new surveyors and an epidemiologist. The Commissioner also stated that the timetable for hospitals' reporting of hospital acquired infections is in progress and on track. Currently non-hospital units are not included but will be in the future.

  The Council requested more information in the form of a report that specifies cost savings and the reduction in cost of health care resulting from the program. The Council also expressed interest in information related to DPH's progress toward developing a set of measures sufficient to enable DPH to ascertain and report to the public each hospital's progress in preventing the full spectrum of infection types occurring in Massachusetts health care settings.
- Serious Reportable Events (SREs)

  JudyAnn Bigby announced that the Commonwealth of Massachusetts HealthyMass agencies will cease paying for all 28 SREs. The HealthyMass agencies are working with the Massachusetts Hospital Association to implement this change. The new policy will affect payments from MassHealth, the Connector, the Group Insurance Commission, and the Department of Corrections.

  Paul Dreyer - Department of Public Health
  Stancel Riley - Board of Registration in Medicine (BORIM)

  Massachusetts hospitals have reported SREs to DPH for 30 years. In December 2007 the Department of Public Health notified hospitals of new requirements to note whether an event meets a specific National Quality Forum (NQF) SRE definition when they report

SREs. DPH also updated its incident reporting form. Mr. Dreyer told the Council that falls account for approximately 65% of SREs reported by hospitals to DPH. He also said that DPH believes SREs are still under-reported and that DPH contacts each hospital regarding potential SREs.

DPH and BORIM are working toward simplifying the reporting form and developing an electronic reporting system.

Council members asked Mr. Dreyer if there have been any attempts made to quantify the average cost of a fall. He indicated that quantification would be very difficult due to the variation in the severity of falls and the resulting treatment.

- Mortality Measure
  Kate Nordahl – Division of Health Care Finance and Policy (DHCFP)

  DHCFP is on target to meet the goal of recommending to the Council a reliable, valid methodology for calculating the ratio of actual mortality to expected mortality for each hospital in the Commonwealth. Assistant Commissioner Kate Nordahl indicated to the Council that representing hospital-wide mortality through a single measure is complex due to adjustments necessary for severity and risk as well as random variation vs. controllable variation.

  DHCFP made the following recommendations:
  - Coordinate with NQF on measurement process;
  - issue RFR to have firms run multiple years of DHCFP hospital discharge database through their "black box" methodologies and to submit their methodologies for evaluation by experts;
  - coordinate with MHA to share results with pilot hospitals;
  - experts will evaluate methodologies and results against QCC principles of reliability and validity and NQF evaluation criteria.

- Physician Order for Life Sustaining Treatment (POLST)
  Ruth Palombo, Executive Office of Elder Affairs
  Andy Epstein, Department of Public Health
  The presentation on Physician Order for Life Sustaining Treatment was delayed until a later meeting.

The meeting adjourned at 4:10 PM.